LAPEER COUNTY COMMUNITY MENTAL HEALTH

ADULT PERSONAL INFORMATION FORM

This information will remain CONFIDENTIAL

Name: _____ DOB: _____ Case Number: _____

Address: _____ S.S. #_____

City, State, & Zip: _____ Phone: _____

Married: ☐Yes ☐No Veteran: ☐Yes ☐No

Emergency Contact_____ Emergency Contact Phone: _____

Emergency Contact Relationship: _____

Are you currently employed? ☐Yes ☐No

Have you experienced any of the following during your employment history?

- Frequently late ☐Yes ☐No
- Frequently absent ☐Yes ☐No
- Have you received verbal/written disciplinary warnings ☐Yes ☐No
- Have you been suspended ☐Yes ☐No
- Have you been fired ☐Yes ☐No
- Have you experienced sexual harassment on the job ☐Yes ☐No
- Have you had a job related accident/injury ☐Yes ☐No
- Have you used drugs/alcohol on the job ☐Yes ☐No
- Have you had verbal/physical fights on the job ☐Yes ☐No
- Are you in danger of losing your job ☐Yes ☐No

Are you satisfied with your job performance? ☐Yes ☐No

Children: ☐Yes ☐No If yes, how many?_____

Do you have a particular cultural identification? ☐Yes ☐No

If yes, how does your cultural or ethnic background influence your life today? _____

_____

PREVIOUS CONTACTS WITH MENTAL HEALTH CENTERS OR PSYCHIATRIC HOSPITALS

Agency/Hospital	Date(s) of Contact	Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____

How would you describe your overall physical health? (Check one)
Very Good ☐ Good ☐ Average ☐ Poor ☐

REVIEW OF PAST/PRESENT MEDICAL CONDITIONS

- Please check any of the following medical problems you have or have had in the past.

____Thyroid
____Adrenal
____Diabetes
____Seizures/Epilepsy
____Syphilis
____HIV/AIDS
____Brain Tumor
____Other: _____

____Head Injury/Loss of Consciousness
____Stroke
____Allergies
____Asthma
____Meningitis or Encephalitis
____Anemia
____Stomach Ulcers

____Kidney/Bladder
____Liver
____Lung
____Heart .
____High Blood Pressure
____Cancer
____Glaucoma

REVIEW OF CURRENT SYMPTOMS OR PROBLEMS

- Please check all items that pertain to you now.

EYES
____Double vision
____Eye pain
____Problems with vision
EARS
____Hearing aid
____Buzzing/ringing in ears
____Infection in ears
____Problems with balance
____Problems with hearing
NOSE
____Nose bleeds
____Stuffed nose
MOUTH
____Loss of taste
____Problems with teeth
____Dentures
RESPIRATORY
____Shortness of breath
____Chronic cough
____Sputum/mucus production
____Positive TB test
____Coughing up blood

GASTROINTESTINAL
____Difficulty swallowing
____Heartburn
____Nausea
____Vomiting
____Diarrhea
____Constipation
____Blood in stools
____Black tarry stools
____Abdominal pain
SKIN/JOINTS/MUSCLES
____Changes in skin
____Changes in nails
____Changes in hair
____Skin rash
____Skin itchy/dry
____Cramps in legs or arms
____Stiff joints
____Swollen joints
NERVOUS SYSTEM
____Headaches
____Numbness
____Fainting spells
____Convulsions/seizures
____Memory problems
____Coordination problems
____Tremor/shakes
____Loss of movement
____Loss of sensation

GENERAL HEALTH
____Overweight
____Underweight
____Chills
____Fever
____Tire easily
____Night or day sweats
GENITO/URINARY
____Pain/burning when urinating
____Frequent urination at night
____Bloody/black/brown urine
____Difficulty starting urine flow
____Constant need to urinate
CARDIOVASCULAR
____High blood pressure
____Low blood pressure
____Heart skips a beat
____Palpitations
____Fast heart rate
____Chest pain
____Swollen ankles
FEMALES ONLY
____Menstrual irregularities
____Menopause
____Problem pregnancy
____Miscarriage
____Abortion
____Premenstrual problems
____Infertility
____Currently pregnant
Date of last menstrual period_____

List any medication you presently take that are prescribed by a doctor:

Name of Medication	Dosage	Times Daily	Prescribed By

List any over the counter medication you presently take: (Include vitamins and supplements)

Name of Medication	Dosage	Times Daily

Are you currently involved in any civil or criminal legal proceedings? ☐Yes ☐No

CHEMICAL USE HISTORY

Drug Category Place a * by drug(s) of choice	Age first used, how much, how often	Maximum use, how much, how often	Use in last 30 days, how much, how often	Date last used and method of use
Nicotine (tobacco)				
Caffeine (coffee, tea, sodas, colas)				
Prescription drugs Percoset, Xanax, Darvon, Librium, Valium, Darvocet				
Alcohol Beer, Wine, Liquor				
Marijuana Pot, Hashish				
Amphetamines, Speed, Crystal meth, Diet pills				
Opiates, Heroin, Dilaudid, Codeine, Talwin, Methadone				
Cocaine / Crack				
Hallucinogenic LSD-acid, PCP, Mescaline, Mushrooms				
Barbiturates, Sedatives, Sleeping pills, Seconal				
Major Psychotropics Thorazine, Stelazine, Mellaril, Haldol				

What is/are your drug(s) of choice (for recreation, relaxation, coping, etc.)? _____

_____

What do you like about using drugs and/or alcohol? _____

_____

Do you ever find yourself using more alcohol / drugs than you intended? ☐Yes ☐No
Is there regular drug / alcohol use at your school / work site? ☐Yes ☐No
Do you use drugs / alcohol with your co-workers / classmates? ☐Yes ☐No
When you use, do you use ☐Alone, ☐In a group, ☐Some of each
How many of your friends use drugs or alcohol? ☐All ☐Some ☐A Few ☐None
Do you ever experience urges or cravings for drugs / alcohol? ☐Yes ☐No